MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06207

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1909 - 2nd St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: GEORGE G. ADAMS

3.(b) Social Security Number: 577-05-1942

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mildred Adams

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): December 26, 1893

8. AGE: Years	Months	Days	If less than one day
53	7	4	hrs. min.

9. Birthplace: Indianapolis, Indiana
(Town, county, and state)

10. Usual occupation: Cab Driver

11. Industry or business: -

FATHER
12. Name: George W. Adams
13. Birthplace: Edenburg, Indiana

MOTHER
14. Maiden name: W. Lindell
15. Birthplace: Newpoint, Indiana

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Prince George's Co., Md.

18. Funeral director: Wm. J. Malley

Address: 3200 - Rhode Isl. Ave. Mt. Rainier, Md.

19. July 30, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 30 1947 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 23 1947, to JULY 30 1947

and that I last saw h... I.M. alive on JULY 30 1947

Immediate cause of death	DURATION
Arterio-sclerotic heart disease with Cardiac decompensation	1 week
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Evidence of Myocardial infarction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 7-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

06208

Reg. Dist. No. 239

1. PLACE OF DEATH:

County: Prince Georges

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 7 yrs

Hospital, institution, or street address where death occurred: Montgomery Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Montgomery Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Rebecca Ault

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James C. Ault

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept 15, 1864

8. AGE: Years: 82 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: John Beavins

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Elizabeth King

15. Birthplace: Maryland

16. Informant: Bessie M. Bauer

Address: Laurel, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 5, 1947 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Baltimore Md

18. Funeral director: R. Ridgley Selby

Address: 401 Washington Ave. Laurel Md

19. July 5 1947 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 19 47, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other

Address: Westville Md Date signed: 7-3-47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 546

06209

CERTIFICATE OF DEATH

Reg. Dist. No. 231

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, Institution, or street address where death occurred: Prince Georges Gen Hospital
How long in hospital or Institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Beardsley, Mrs, Charlotte

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife Ervin L. Beardsley.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 23, 1890

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace Manistique Michigan
(Town, county, and state)
10. Usual occupation Clerk
11. Industry or business

FATHER
12. Name John A Freeman
13. Birthplace Michigan

MOTHER
14. Maiden name Emily Sandberg
15. Birthplace Sweden

16. Informant daughter - Mrs Florence Roberts
Address Cheverly, Md (6015 Kilmore)

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29, 1947. (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland Md
18. Funeral director E Grecha & Son
Address Hyattsville Md

19. 7/29 1947 (Date rec'd by registrar) Amanda Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 July 1947, at 9 10/P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-14 1947, to 7-26 1947
and that I last saw h... alive on 7-26 1947

Immediate cause of death	DURATION
Pulm Emb cerebral edema	3 days
Due to Glioblastoma multiforme (brain tumor malignant), left temporal lobe	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Brain tumor Date of op. 7-23-47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J Murphy MD M. D. or other
Address 2014 R St NW Date signed 7-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95c

CERTIFICATE OF DEATH

S 06210

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Prince Geo. Co.
County 713 Dovenshire St.
City or town Takoma Pk. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 414 Emerson Street N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ada E. Bone

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife William J.F. Bone
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 26, 1874

8. AGE: Years	Months	Days	If less than one day
72			..... hrs. ..... min.

9. Birthplace Alberta, Canada
(Town, county, and state)

10. Usual occupation Christian Science Practitioner

11. Industry or business

FATHER
12. Name -----Guthrie
13. Birthplace Scotland

MOTHER
14. Maiden name -------
15. Birthplace ------

16. Informant Mrs. Helen L. Machen
Address 4915 3rd Street N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/12/47 (month) (day) (year)
Cemetery or crematory Ft. Lincoln Cem.
Location 3201 Bladensburg Rd.

18. Funeral director The D.H. Hines Co
Address 2901 - 14th St N.W.

19. July 9 1947 James Seray Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1947, to July 9 1947 and that I last saw h. E.R. alive on JULY 9 1947

Immediate cause of death Cardiac dilatation — DURATION 4 hrs.

Due to general debility of old age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. A. Sherman M.D
M. D. or other
Address 112 Carroll St. N.W. Date signed July 9, '47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170c

CERTIFICATE OF DEATH

S 06211 2432

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George's
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
Ritchie Marlboro Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5032 D Street S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Edward Bowser

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Charity Bowser
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): October 18, 1910

8. AGE: Years	Months	Days	If less than one day
36			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Brick layer
11. Industry or business: Building

FATHER
12. Name: Albert Bowser
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Moore
15. Birthplace: Virginia

16. Informant: Lucy Corry
Address: 5026 D Street S.E., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25 1947 (month) (day) (year)
Cemetery or crematory: Suitland Cem.
Location: Suitland Maryland
18. Funeral director: Henry S. Washington & Sons
Address: 467 N St. N.W. Wash D.C.
19. July 22 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 19 47 at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed chest	
Due to:	
Other conditions: Multiple lacerations to the face and chest	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 7/21/47
Where did injury occur? Upper Marlboro (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Ritchie Road.
Means of injury: Driver of a car in a collision Injured at work?

23. SIGNATURE: Deputy Medical Examiner M.D. or other
Address: Forestville, Md. Date signed 7/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

06212

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: Mitchellville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred: Cram Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Odenton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D #1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Henry Chesley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1, 1930

8. AGE: Years: 16 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: John T. Chesley

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Martha Coates

15. Birthplace: Maryland

16. Informant: John T. Chesley

Address: Odenton Md R.F.D #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2, 1947 (Month) (day) (year)

Cemetery or crematory: Forks Cemetery

Location: Patuxent Md

18. Funeral director: T. Gaskie sons

Address: Hyattsville Md

19. 8/2 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1947 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 7-30-47

Where did injury occur? Mitchellville P.G. Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Cram Highway

Means of injury: Struck by truck Injured at work? yes

Deputy medical examiner

23. SIGNATURE: M. D. or Other

Address: Forestville Md Date signed: 8-1-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Inaccuracy is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06213

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 6 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 N. St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles E. Colbert

3.(b) Social Security Number: 577-09-3386

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Adaline Quander

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1885

8. AGE: Years	Months	Days	If less than one day
62 62	2	26	hrs. min.

9. Birthplace: Upper Malboro, Maryland
(Town, county, and state)

10. Usual occupation: Cleaner in Boiler Room

11. Industry or business: Benning Power Plant

FATHER
12. Name: Richard Colbert
13. Birthplace: ? Maryland

MOTHER
14. Maiden name: Susan Clark
15. Birthplace: ? Maryland

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 1, 1947 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D.C.

18. Funeral director: Purple Funeral Home

Address: 2304 Ga. Ave N.W.

19. July 31, 1947 Rowland S. Phelps
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 - 1947 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/24 1947, to 7/31 1947 and that I last saw h[illegible] alive on 7/31/47 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 9 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 7/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06214

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bladensburg Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Bladensburg, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4703 Varnum St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Elizabeth Dade

3.(b) Social Security Number:

4. Sex: F
5. Color or race: C
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Isadore Dade
6.(c) If alive, give age: 38 years
7. Birth date of deceased (mo., day, yr.): October 18, 1911
8. AGE: Years: 35 Months: 9 Days: 11 If less than one day: hrs. min.
9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housekeeper-Beautician
11. Industry or business: Own home
12. FATHER — Name: John Williams
13. FATHER — Birthplace: unknown
14. MOTHER — Maiden name: Emma Willis
15. MOTHER — Birthplace: Westmoreland Co. Va.
16. Informant: Emma Thurbeur
Address: Bladensburg Md. 4703 Varnum St.
17. Burial, cremation, or removal. Which?: Removal Date thereof: July 29, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: E. Ernest Jarvis Co.
Address: 1432 You St NW
19. 7/29 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1947 at 3:50 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1947 to July 29 1947 and that I last saw h alive on July 29th 1947
Immediate cause of death: Myocardial Insufficiency of Mitral valve. — DURATION: 1-2 yr.
Due to: Overwork and Heart conditions — DURATION: ?
Due to: — DURATION:
Other conditions: Nephritis chronic with hypertension — DURATION: 3-4 yrs.
(Include pregnancy within 3 months of death)
Major findings of operations: — Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: no Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William H. Spillan M.D.
M. D. or other
Address: 4906 R.I. Ave. Brentwood Md. Date signed: 7-29-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

06215

CERTIFICATE OF DEATH

Reg. Diat. No. 745

1. PLACE OF DEATH:
County Prince Georges
City or town M. Brentwood, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town M. Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4503 Banner Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Jane Davis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C.	Widow

6.(b) Name of husband or wife Isaac Davis deceased
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 19, 1864

8. AGE: Years	Months	Days	If less than one day
82	10	26	hrs. min.

9. Birthplace Pittsylvania Co. Va. (Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business Own home

FATHER
12. Name Ephraim Davis
13. Birthplace Pittsylvania Co. Va.

MOTHER
14. Maiden name Charlotte Tucker
15. Birthplace Pittsylvania Co. Va.

16. Informant Elizabeth Lindsey
Address 4506 Banner St. M. Brentwood Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7, 30, 47 (month) (day) (year)
Cemetery or crematory Maryland Memorial Park
Location Washington D.C.
18. Funeral director Thos Fraser
Address 3895 R.I. Ave. NW
19. July 27 1947 (Date rec'd by registrar) James Levey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947 at 3:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22 1947 to July 27 1947
and that I last saw her alive on July 24 1947

Immediate cause of death	DURATION
Chronic Myocarditis	1-2 yr.
Due to Age & Work	
Due to	
Other conditions Hypertension	1-2 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William H. Speller M.D.
M. D. or other
Address 4506 R.I. Ave Brentwood Md. Date signed 7-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JUL 30 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06216

47c

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County: Prince George's
City or town: Townsend (Brandywine)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
At Home
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. George's
City or town: Townsend (Brandywine)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: See above
(If rural, give LOCATION)
2.(a) If veteran, name war: ---666-----

3.(a) FULL NAME: Marco DeCesaris

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida Jannette DeCesaris
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): February 13, 1896

8. AGE:

Years	Months	Days	If less than one day
51	5	5	... hrs. ... min.

9. Birthplace: Notaresio Italy (Town, county, and state)
10. Usual occupation: Contractor and Builder
11. Industry or business: Contractor and Builder
FATHER
12. Name: Geatan DeCesaris
13. Birthplace: Italy
MOTHER
14. Maiden name: Josephine DeSantis
15. Birthplace: Italy
16. Informant: Charles E. DeCesaris
Address: Brandywine, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22 /47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln, D.C.
Location: D. C.
18. Funeral director: Thomas B. Hanlon
Address: 641 H. St. N.E.
19. July 19 1947 (Date rec'd by registrar) F.H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 19 47 at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1946 to July 1 19... and that I last saw him alive on July 17 1947

Immediate cause of death	DURATION
Pulmonary and circulatory collapse	
Due to internal hemorrhage	
Due to Bronchogenic Carcinoma with diffuse metastases	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations: Bronchogenic CARCINOMA with metastases
Date of op.: Mar. & May 47
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Alfred R. Lapen, M.D.
M. D. or Other
Address: AQUASCO, MD. Date signed: July 18, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164d

06217

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Georg's

City or town: Berwyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9022 - 48th Pl.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Byron Dixon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mevie Lee Dixon

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): July 26, 1875

8. AGE: Years: 71 | Months: 11 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Prince Georg's County, Md. (Town, county and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER — 12. Name: Benjamin Franklin Dixon

13. Birthplace: ? Md.

MOTHER — 14. Maiden name: Susanna Phipps

15. Birthplace: ? Md.

16. Informant: Leland Memorial Hospital Record

Address: Riverdale, Md

17. (Burial, cremation, or removal, which?) Burial Date thereof: July 5-47 (month) (day) (year)

Cemetery or crematory: Episcopal Church Cemetery

Location: Fortestville, Md.

16. Funeral director: W W Chaconas Co

Address: Riverdale, Md.

19. July 4 1947 (Date rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20D. DATE OF DEATH: July 3 1947, at 6.20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Tetanus	
Due to: Laceration on neck	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of injury: June 29, 1947

Where did injury occur? Hyattsville (City or town) Md. (County) (State)

Injured at home, farm, industry, public place (where?): Street

Means of injury: Cut throat with razor

Deputy Medical Examiner

23. SIGNATURE: ..... M. D. or other

Address: Forestville, Md. Date signed: 7-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06218

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos., 18 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 4 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1706 R. St., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ADA DORSEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 30, 1894

8. AGE: Years	Months	Days	If less than one day
52 52	8	0	hrs. min.

9. Birthplace: Cerro Gordo, North Carolina (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: War Department

FATHER
12. Name: William J. Dorsey
13. Birthplace: Morgantown, North Carolina

MOTHER
14. Maiden name: Bessie Charlotte Anderson
15. Birthplace: Adrian, South Carolina

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 30, 1947 (month) (day) (year)
Cemetery or crematory
Location: to Washington, D.C.
18. Funeral director: S. H. Hines Co.
Address: 2901 - 14th St. N.W.
19. July 30, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 19 47 at 6 50 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/11 19 47 to 7/30 19 47 and that I last saw h. alive on 7/30 19 47

Immediate cause of death	DURATION
pulm. tuberculosis	7 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md. Date signed 7/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

06219

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Pr. George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Pr. Geo. Genl Hosp.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr. Geo.
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4100 Oliver St.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME Dunbar, Mr. William

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22 1878

8. AGE: Years 69 | Months | Days | If less than one day hrs. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Painting Contractor

11. Industry or business

FATHER
12. Name John Dunbar
13. Birthplace Scotland

MOTHER
14. Maiden name Marguerite McIntosh
15. Birthplace Scotland

16. Informant Mr. James W. Dunbar
Address 4100 Oliver St. Hyattsville

17. Burial Date thereof Aug 1, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Washington D.C.

18. Funeral director F. Gudelsky Sons
Address Hyattsville Md

19. 7/31 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1947 at 7.05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1947 to July 29 1947 and that I last saw h... alive on July 29 1947

Immediate cause of death	DURATION
Pulmonary Congestion + Pneumonia	
Due to: Pulmonary Emphysema	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

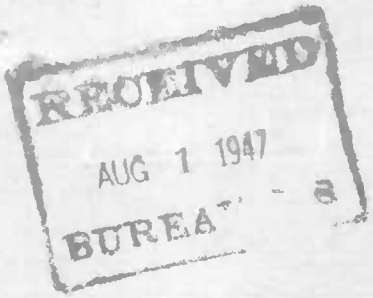
23. SIGNATURE Louis M. Grimes M.D.
M. D. or other
Address Cottage City Md. Date signed 7-29-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)


RECEIVED
AUG 1 1947
BUREA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

06220

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Pr.Geo.
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7hrs.10min.
Hospital, institution, or street address where death occurred: Pr.Geo.Gen'l
How long in hospital or institution? 7hrs.10min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr.Geo.
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5712 Greenleaf Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dyott, Mrs. Dorothy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W	M

6.(b) Name of husband or wife: J.Spencer Dyott
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1914

8. AGE: Years	Months	Days	If less than one day
33			hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Joseph H.Hahn
13. Birthplace: Md.

MOTHER
14. Maiden name: Clara Myers
15. Birthplace: Md.

16. Informant: James S Dyott
Address: Cheverly Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26. 1947 (Month) (day) (year)
Cemetery or crematory: Pleasant Valley Cemetery
Location: Westminster Md.

18. Funeral director: F Vaccia Sons
Address: Hyattsville Md.

19. 7/24 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-23 19 47 at 6:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebro-vascular accident	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of nperatinns:
Date of op.:

Antopsy results:
PHYSICIAN: Please underline the canse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other
Address: Hyattsville Md. Date signed 7-23-47


RECEIVED
JUL 29 1947
BUREAU

06221

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County: PRINCE GEORGE'S
City or town: BRANDYWINE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
Brandywine
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo's
City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: THOMAS HOLLIDAY EARLY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: Nellie Squires Early
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1876

8. AGE:

Years	Months	Days	If less than one day
71	2	21	hrs. min.

9. Birthplace: Brandywine, Pr. Geo, Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Charles Stewart Early
13. Birthplace: Brandywine Md.

MOTHER
14. Maiden name: Georgia Berry
15. Birthplace: Forestville Md.

16. Informant: Nellie Squires Early
Address: Brandywine Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 3 47 (month) (day) (year)
Cemetery or crematory: St. Paul's
Location: Baden Maryland

18. Funeral director: Ritchie Brothers
Address: Upper Marlboro, Md.

19. July 2 1947 (Date rec'd by registrar) F. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 1 1947 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 1946, to JULY 1947
and that I last saw him alive on JUNE 23 1947

Immediate cause of death	DURATION
CIRCULATORY COLLAPSE	
Due to VALVULAR HEART DISEASE + PULMONARY EDEMA	
Due to CARDIO VASCULAR DISEASE	
Other conditions ARTERIOSCLEROSIS + HYPERTENSION	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Alfred R. Lapen M.D. M. D. or other
Address: Aquasco, Md. Date signed: July 4, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUL 16 1947

06222

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Diat. No. 239

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince George's
City or town Laurel, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 715 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Easton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Elizabeth Easton 6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	12	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Easton
13. Birthplace Maryland

MOTHER 14. Maiden name Caroline Easton
15. Birthplace Maryland

16. Informant Arthur Easton
Address Main St Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14 1947 (month) (day) (year)
Cemetery or crematory Ivy Hill
Location Laurel Md

18. Funeral director Ridgely Selby
Address 401 Wash. Ave. Laurel Md

19. July 13 1947 (Date rec'd by registrar) W. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947, at 8 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1947 to July 11 1947
and that I last saw him alive on July 11 1947

Immediate cause of death	DURATION
Carcinoma Thrombosis & Ca	
Due to Arteriosclerosis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. M. Warren MD M. D. or other
Address Laurel Date signed 7/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06223

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ing correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 mos., 8 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 2 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 714½ O. Street, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JAMES A. EDWARDS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Ollie D. Edwards

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 10, 1892

8. AGE: Years	Months	Days	If less than one day
54 54	10	13	hrs. min.

9. Birthplace: Orangeburg, South Carolina
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER
12. Name: Ned Edwards
13. Birthplace: Orangeburg, South Carolina

MOTHER
14. Maiden name: Mussie Edwards
15. Birthplace: Orangeburg, South Carolina

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof 7-24-47 (month) (day) (year)

Cemetery or crematory: To Washington DC

Location:

18. Funeral director: Frazier Funeral Home DC

Address: 389 R. I. Ave N.W.

19. 7-24 1947 (Date rec'd by registrar) Rowland L. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 23 1947, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 14 1946, to JULY 23 1947 and that I last saw h... IM alive on JULY 23 1947

Immediate cause of death	DURATION
Meningitis, tuberculous	2 days
Due to: PULMONARY TUBERCULOSIS	2 yrs
Due to:	
Other conditions: DIABETES MELLITUS	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 7/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06224

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 8 mos., 16 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 8 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1337 - 5th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DAVID EVANS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Rosa Evans

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): September 29, 1881

8. AGE: Years	Months	Days	If less than one day
65	10	2	hrs. min.

8. Birthplace: Hoke Co., North Carolina
(Town, county, and state)

10. Usual occupation: none, the last 10 years.

11. Industry or business: —

FATHER
12. Name: Frank Evans
13. Birthplace: ? North Carolina

MOTHER
14. Maiden name: Katie McLean
15. Birthplace: ? North Carolina

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 4, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D. C.

18. Funeral director: Maloney & Schey, Inc.

Address: 424 - R St. N. W.

19. July 31, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 47, at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/14 19 45, to 7/31 19 47

and that I last saw h... alive on 7/31 19 47

Immediate cause of death	DURATION
pulm. Tuberculosis	9½ yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: July 31, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137e

06225

CERTIFICATE OF DEATH

Reg. Diat. No. 231

M

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days and 20 min.

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? 7 days and 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3811-39th Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

FEES, Mr. Benjamin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1858-15-7

8. AGE:

Years	Months	Days	If less than one day
89	0	10	hrs. min.

9. Birthplace: Jonestown, Pa.
(Town, county, and state)

10. Usual occupation: Retired miller

11. Industry or business

FATHER
12. Name: Joseph Fees
13. Birthplace: Pa.

MOTHER
14. Maiden name: Susannah Westenberger
15. Birthplace: Pa.

16. Informant: Mrs. Ida Mae Donley (Daughter)
Address: 3811-39th St., Brentwood, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/26/1947 (month) (day) (year)

Cemetery or crematory:

Location: Tower City Pa.

18. Funeral director: Wm. J. Ballin

Address: 3200-R. I. Ave. Mt. Rainier Md

19. 7/26 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-25 1947 at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-18 1947, to 7-25 1947 and that I last saw him alive on 7-25 1947

	DURATION
Immediate cause of death: Uremia 132.2	10 days
Due to: Prostatic Obstruction 137e	2 weeks
Due to: Urinary Tract Infection	1 year
Other conditions: Senility	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other

Address: Mt. Rainier Md Date signed: 7-25-47

I

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VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore · 49d

06226

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: P.G. Co.

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: P.G. Co.

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5900 Addison Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Wilhelmena Tayze

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W.	W.

6.(b) Name of husband or wife: James Henry Tayze

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1858

8. AGE:	Years	Months	Days	If less than one day
	89			..... hrs. ..... min.

9. Birthplace: Wash. D.C. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER

12. Name: James Henry Tayze

13. Birthplace: Va.

MOTHER

14. Maiden name: Sarah Killian

15. Birthplace: Germany

16. Informant: Reades Tayze

Address: Seat Pleasant

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26, 1947 (month) (day) (year)

Cemetery or crematory: Prospect Hill

Location: Washington D.C.

18. Funeral director: F. Bloche Sons

Address: Hyattsville Md

19. 7/24 1947 (Date rec'd by registrar) Amanda Dewey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1947, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1947, to July 23 1947 and that I last saw h.. alive on July 23 1947

Immediate cause of death	DURATION
Carcinoma of the uterus	
Cellulitis of face	
Due to	
Due to	
Other conditions: Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hyman J. Zimmerman M.D. (M. D. or other)

Address: 6809 Coolidge Date signed July 23, 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92a

06227 245

CERTIFICATE OF DEATH

Reg. Diat. No. 246

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Mt. Rainier, Maryland
City or town 4012 29th St.,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4012 29th Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anna Elnora Garland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife -
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18, 1884

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Registered Nurse-retired
11. Industry or business

FATHER
12. Name William Henry Garland
13. Birthplace Virginia

MOTHER
14. Maiden name Sarah Ford
15. Birthplace Virginia

16. Informant Mrs. Hattie G. Iglehart
Address

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JULY 21 1947 (month) (day) (year)
Cemetery or crematory ROCK CREEK CEMETERY
Location WASHINGTON, D.C.
18. Funeral director S. H. Hines Co
Address 2901 - 14th St. N.W.

19. 7/18 19 47 Wm. G. Yates Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION 7/18/47

20. DATE OF DEATH July 18 19 47, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st - 1930, to July 17th 1947
and that I last saw her alive on July 17th 47, 19

Immediate cause of death	DURATION
Cardiac Paralysis.	12 hrs.
Myocardial degeneration +	
Endocardial valve changes	
Due to Cardio-vascular disease	
Due to Unknown causes.	18-20 years.
Other conditions -	

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. R. Moulden M.D.
M. D. or other
Address 3401 - Lowell N.W. Date signed 7-18-47

06228

06228

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George's

City or town Cedar Hills (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred:

5222 - P St A E.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Cedar Hills (If outside city or town limits, write RURAL and give nearest town)

Street No. 5222 P Street A E (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lena Garlington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married.

6.(b) Name of husband or wife Eugene Garlington

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) June 13, 1877

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Ephriam Ferrell

13. Birthplace Virginia

MOTHER 14. Maiden name Mary Walker

15. Birthplace Virginia

16. Informant James W. Potts

Address 5222 P St A E. Cedar Hills

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland, Md.

18. Funeral director J. William Lee Sons Co

Address 360 4th St. N.E. D.C.

19. July 9 1947 (Date rec'd by registrar) Carrie J. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy medical Examiner

23. SIGNATURE James L. Floyd M. D. or other

Address Seatville Md Date signed 7-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06229

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1214 Lamont St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Marshall Gibbs

3.(b) Social Security Number: 178-12-6033

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 7, 1917

8. AGE: Years	Months	Days	If less than one day
30	5	12	hrs. min.

9. Birthplace: Vidella, Georgia
(Town, county, and state)

10. Usual occupation: Elevator Operator

11. Industry or business:

FATHER — 12. Name: March Gibbs

13. Birthplace: ? Georgia

MOTHER — 14. Maiden name: ?

15. Birthplace: ? Georgia

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 19/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: W Ernest Jarvis Co

Address: 1432 You St NW

19. July 19, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 - 1947 at 2:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/18 1947 to 7/19 1947 and that I last saw h[illegible] alive on 7/19 - 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	10 Mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 7/19/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
JUL 29 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06230

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs., 10 mos., 18 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 yrs., 10 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5351 Hayes St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: GIBSON, KATHERINE ELIZ.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 18, 1921

8. AGE: Years	Months	Days	If less than one day
25 25	11	1	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Charles Gibson
13. Birthplace: Washington, D. C.

MOTHER — 14. Maiden name: Estelle Buckner
15. Birthplace: Washington, D. C.

16. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which?: Removal — Date thereof: July 19/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Henry S. Washington & Son

Address: 467 M St. N.W.

19. July 19, 1947 (Date rec'd by registrar) — Rowland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1947, at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/30 1941, to 7/19 1947

and that I last saw h... alive on 7/19 1947

Immediate cause of death: pulm. tuberculosis — DURATION: 6 years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale Md. Date signed: 7/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 29 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 191

CERTIFICATE OF DEATH

06231

Reg. Dist. No. 745

1. PLACE OF DEATH:
County: Prince George's
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Dead on arrival
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2501 Arundel Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Meryl Louise Reynolds Glenn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 11, 1947

8. AGE: Years	Months	Days	If less than one day
	1	16	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Joseph Burton Glenn Jr.
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Jane Holcombe Hearin-Simon
15. Birthplace: Washington, D.C

16. Informant: Jane S. Glenn
Address: 2501 Arundle Road, Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29, 1947 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Washington D.C.

18. Funeral director: F. Lincoln Ogle
Address: Hyattsville Md

19. July 29 1947 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 47 at 6:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Heat Stroke	
Due to: Exposure to excessive heat	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 7/27/47
Where did injury occur? Mt. Rainier (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Nature of injury: Left in an overheated room Injured while at work?

Deputy Medical Examiner

23. SIGNATURE: [signature] M. D. or other
Address: Forestville, Md. Date signed 7/28/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

06232

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month and 5 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1402 I. Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME John Graham

3.(b) Social Security Number 577-14-9802

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 20, 1907

8. AGE: Years	Months	Days	If less than one day
40	2	20	..... hrs. ..... min.

9. Birthplace: McBee, South Carolina
(Town, county, and state)

10. Usual occupation: Washes rolers in printing machines

11. Industry or business: -

FATHER
12. Name: Albert Graham
13. Birthplace: McBee, South Carolina

MOTHER
14. Maiden name: Janie Davis
15. Birthplace: McBee, South Carolina

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10, 1947 (month) (day) (year)
Cemetery or crematory: Harmony Cemetery
Location: Washington D.C.

18. Funeral director: James E. Chinn
Address: 1508 - 9th St. N.W., Washington D.C.

19. July 10 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1947 at 7 35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/4 1947 to 7/10 1947
and that I last saw h[illegible] alive on 7/10 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale Md. Date signed: 7/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

STATE OF MARYLAND—CERTIFICATE OF DEATH

06233

159

1. PLACE OF DEATH

County Prince Georges Registration Dist. No. 231

Village or City Laurel Hospital, Md. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Lenwood Harrison Gray

(a) Residence: No. [illegible] St., Ward, Seat Pleasant, Md.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) July 7, 1947

7. AGE Years ... Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. ...

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. ...

10. Date deceased last worked at this occupation (month and year) ... 11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) Seat Pleasant, Md

(State or country) Prince Georges Co. Md

FATHER

13. NAME Bernard Hamilton Gray

14. BIRTHPLACE (city or town) Washington, D.C.

(State or country)

MOTHER

15. MAIDEN NAME Lucy Jane Gray

16. BIRTHPLACE (city or town) Middleburg, Va.

(State or country)

17. INFORMANT Mrs. Bernard Gray

(Address) Seat Pleasant, Md

18. BURIAL, CREMATION, OR REMOVAL Private, 7/8 Date 7/8, 1947

Prince Geo. Co. Md.

19. UNDERTAKER Ritchie Bros.

(Address) Upper Marlboro, Md.

20. FILED 7/8, 1947 Amanda Downey

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July 7, 1947

(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 7, 1947, to July 7, 1947

I last saw him alive on July 7, 1947; death is said to have occurred on the date stated above, at 10 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

Prematurity 6 months July 7 1947

Other **Contributory Causes** of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) Dr. R. A. Pearson, M.D.

(Address) Seat Pleasant, Md. 7/8/47

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170C

06234

CERTIFICATE OF DEATH

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Prince George's

City or town Upper Marlboro (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: Marlboro Ritchie Road

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince Geoge's

City or town Ceder Heights (If outside city or town limits, write RURAL and give nearest town)

Street No. 1108 64th Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Celestine Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Arthur Green Jr.

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 1, 1919

8. AGE: Years	Months	Days	If less than one day
28			hrs. min.

9. Birthplace Washington, D.C (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name C. J. Nixon

13. Birthplace North Carolina

MOTHER 14. Maiden name Fannie Gordon

15. Birthplace Virginia

16. Informant Arthur Green Jr.

Address 1108 64th St. Ceder Heights, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 22 1947 (month) (day) (year)

Cemetery or crematory Thomas Frazier Funeral Parlor

Location 389 R. I. Ave N.W. Wash D.C.

18. Funeral director Thomas Frazier

Address 389 R. I. Ave N.W. Wash D.C.

19. July 22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947 at 11:30P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Crushed chest Fracture of the skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/21/47

Where did injury occur? Upper Marlboro P. G. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Ritchie Road

Means of injury Passenger in a car that was in a collision

Deputy Medical Examiner

23. SIGNATURE James T. Boyd M. D. or other

Address Forestville, Md. Date signed 7/22/47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06235

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 745

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George's

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6112 - 44th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Leonard Harrison Green

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lois Gerry Green

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 19, 1884

8. AGE:

Years	Months	Days	If less than one day
63		10	..... hrs. ..... min.

9. Birthplace: ? (Town), Penna (county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER

12. Name: William Green

13. Birthplace: ? Penna

MOTHER

14. Maiden name: Mary Ella Coolidge

15. Birthplace: ? Penna

16. Informant: Leland Memorial Hospital Records

Address: Riverdale, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1, 1947. (month) (day) (year)

Cemetery or crematory: Arlington Cemetery

Location: Da

18. Funeral director: F Gaeke & Son

Address: Hyattsville Md.

19. July 31 1947 (Date rec'd by registrar) James Geevy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1947 at 1:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939 to July 29 1947

and that I last saw him alive on July 29 1947

Immediate Cause of death	DURATION
Congestive Heart Failure	
Due to Arteriosclerotic Heart Disease with Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L W Mallon MD M. D. or other

Address: Riverdale, Md Date signed 7-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

06236

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:
County Prince George's
City or town Capital Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
303 61st Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Capital Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 61st Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
James Arthur Greer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Eda V. Greer
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 8, 1884

8. AGE:	Years	Months	Days	If less than one day
	63			hrs. min.

9. Birthplace Aquasco, Md.
(Town, county, and state)

10. Usual occupation Foreman

11. Industry or business Ware house

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Franklin A. Greer
Address 303 61st Street, Capital Heights, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 7-16-47 (month) (day) (year)
Cemetery or crematory Glenwood
Location

18. Funeral director W. W. Chambers & Co.
Address 5711 4th St. S.E. Capitol Hts. Md.

19. Filed 7-17 1947 Carlos Campbell, Registrar
(Date rec'd by registror)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947, at 2:45A

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
, 19, to 19
and that I last saw h alive on 19

Immediate cause of death	Pulmonary embolism	DURATION
Due to	Thrombosis of femoral vein	
Due to	Fracture of the right patella	1 month
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results given above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 6/12/47
Where did injury occur? Washington (City or town) D.C. (County) (State)
Injured at home, farm, industry, public place (where?) Ware house
Means of injury fell on floor Injured at work? Yes

23. SIGNATURE Deputy Medical Examiner James J. Jones M. D. Coroner
Address Forestville, Md. Date signed 8/5/47

MARGIN RESERVED FOR BINDING

To replace previous certificate see other side

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

This man died July 13, 1947 at 2:45 A.M. at that time he was pronounced dead by Dr. Zimmerman.

The follwoing day Dr. Brainin, who had been away , signed the death certificate.

The informant Mr.Franklin A. Greer says that James Arthur Greer, his father, was never a patient of Dr. Brainin's and that at no time since his death has Dr. Brainin seen him.

Autopsy did not show any evidence of coronary thrombosis, the cause of death given on the certificate.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 2

CERTIFICATE OF DEATH

06237

Reg. Dist. No. 245

1. PLACE OF DEATH:
County PRINCE GEORGE'S
City or town RIVERDALE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 MONTHS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr. George.
City or town Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6415 Taylor Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war None.

3.(a) FULL NAME ANNIE JOSEPHINE GRIFFIN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DEC 10 1914

8. AGE: Years 32 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace ST. JOHNS NEWFOUNDLAND (Town, county, and state)

10. Usual occupation Sales lady.

11. Industry or business

FATHER 12. Name JOHN J GRIFFIN
13. Birthplace ST. JOHNS NEWFOUNDLAND

MOTHER 14. Maiden name ELLEN SAVIDANT
15. Birthplace ST. JOHNS NEWFOUNDLAND

16. Informant MR JOHN J GRIFFIN SR
Address 6415 TAYLOR RD, RIVERDALE

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26, 1947 (month) (day) (year)
Cemetery or crematory Washington Nat.
Location Suitland, Pr Geo Cy., Md.

18. Funeral director W. W. Chambers
Address Riverdale, Md.

19. July 25 1947 Mrs. Jas. Severed Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1947, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18-47 1947, to 7-24 1947 and that I last saw her alive on 7-24-47 1947

Immediate cause of death	DURATION
Carcinoma of colon with metastatic lesion	
Due to lung & spine	18 Mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John P. Clum M.D.
M. D. or other
Address Hyattsville Md Date signed 7-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

06238

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prs Geo Co
City or town: seat Pleasant Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prs Geo Co
City or town: seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7097 Central Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rosie E. Hammett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	

6.(b) Name of husband or wife: samuel J. Hammett
6.(c) If olive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 4. 1859

8. AGE: Years 88 | Months — | Days — | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Henry Bowen
13. Birthplace: Md.

MOTHER — 14. Maiden name: sallie simmons
15. Birthplace: Md.

16. Informant: Mrs Lillian Bowen
Address: seat Pleasant Md

17. Burial: — (Burial, cremation, or removal. Which?) Date thereof July 27. 1947 (month) (day) (year)

Cemetery or crematory: Central Boston
Location: near Prince Frederick Md.

18. Funeral director: J Gaeck's sons
Address: Hyattsville Md

19. 7/29 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 July 1947, at 2 15/D M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 21 1947 to July 23 1947 and that I last saw her alive on July 23 1947

	DURATION
Immediate cause of death: Pneumonia	1 wk
Due to: Arteriosclerotic Cardio Vascular-Renal Disease	2 wk
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R K Sasscer M. D., or other
Address: Upper Marlboro, Md Date signed: 24 July 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06239

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos., 8 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 I. Street, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: CHARLES H. HART

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Hattie Hart

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): October 9, 1903

8. AGE: Years	Months	Days	If less than one day
43 43	9	4	hrs. min.

9. Birthplace: Orangeburg, South Carolina
(Town, county, and otate)

10. Usual occupation: Laborer

11. Industry or business: - -

FATHER
12. Name: Charles Hart
13. Birthplace: Orangeburg, South Carolina

MOTHER
14. Maiden name: Rebecca Hartwell
15. Birthplace: Orangeburg, South Carolina

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 14 47 (month) (day) (year)

Cemetery or crematory

Location: Washington D. C.

18. Funeral director: Hall & Stewart Fu.

Address: 730 "H" St. NE. Wash., D.C.

19. July 13, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1947 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4, 1947 to July 13, 1947 and that I last saw h. alive on July 13, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 mo.
Due to	
Due to	
Other conditions Ischio-rectal abscess	20 da.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: July 13, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06240

Reg. Dist. No. 232

1. PLACE OF DEATH:

County: Pr. Geo.

City or town: Croom - Rural 1/2 mi west.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Rural - Croom
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1/2 mi - west
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Jennie Louise Hensley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	widowed

6.(b) Name of husband or wife: Randolph Hensley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11, 1880

8. AGE: Years: 66 | Months: 11 | Days: 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Prince George Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Henry Batson
13. Birthplace: York

MOTHER
14. Maiden name: Minnie Pongee
15. Birthplace: Meadows, Md

16. Informant: Grace Watson

Address: Brandywine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10 1947 (month) (day) (year)

Cemetery or crematory: Hunters Bethel

Location: T. B. Md.

18. Funeral director: J. B. Johnson

Address: Undertaking

19. July 8 1947 (Date rec'd by registrar) R. Bruce Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 July 1947, at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Dec 1946 to 6 July 1947 and that I last saw h.e.r alive on 4 July 1947

Immediate cause of death	DURATION
Uremia	4 days
Due to: Arteriosclerotic Cardio Vascular-Renal Disease	Unk
Due to:	
Other conditions: Hypertension	10 years

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Robert B. [redacted] Sasser M. D.

Address: Upper Marlboro, Md. Date signed 6 July 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

06241

Reg. Dist. No. 239

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Permanent
Hospital, Institution, or street address where death occurred: Warners Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant, give residence of mother)
State: Maryland County: Howard
City or town: Savage (If outside city or town limits, write RURAL and give nearest town)
Street No.: Box 12 (If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3. (a) FULL NAME: Stanley Le Roy Holmes
3. (b) Social Security Number: 219-18-8022.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Blanche Mae Holmes
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): January 1, 1925
8. AGE: Years 22 Months 6 Days 1 If less than one day ..... hrs. ..... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Mill Operator
11. Industry or business:
FATHER 12. Name: Preston V. Holmes
13. Birthplace: Virginia
MOTHER 14. Maiden name: FANNIE SARGENT.
15. Birthplace: VIRGINIA.
16. Informant: PRESTON V. HOLMES.
Address: SAVAGE, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16, 1947. (month) (day) (year)
Cemetery or crematory: ARLINGTON NAT'L CEM.
Location: ARLINGTON, VA.
18. Funeral director: J. ARTHUR WALTERS FUNERAL HOME.
Address: 505 WASHINGTON BLVD., LAUREL, Md.
19. 7-15 (Date rec'd by registrar) 1947 Cora E. Wachter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1947 at 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure.	
Due to: Coronary occlusion.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?
23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Westville Md. Date signed: 7-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47c

06242

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County PRINCE GEORGES
City or town Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: PRINCE GEORGES Co. HOSP.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County PRINCE GEORGES
City or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6412 - Elliot Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME SARAH JEWLER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	

6.(b) Name of husband or wife SAMUEL JEWLER
6.(c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual occupation HOUSE WIFE
11. Industry or business
FATHER 12. Name GEORGE CHOBOK
13. Birthplace RUSSIA
MOTHER 14. Maiden name FANNY PHEFFERING
15. Birthplace RUSSIA
16. Informant MORRIS JEWLER
Address 6412 - Elliot Pl.
17. removal (Burial, cremation, or removal. Which?) Date thereof July 4/47 (month) (day) (year)
Cemetery or crematory Wash. D.C.
Location
18. Funeral director B Damansky & Son
Address 3501-14th St NW
19. July 4 1947 (Date rec'd by registrar) Amanda Doona Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 July 1947, at 1:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to 4 July 1947 and that I last saw her alive on July 4 1947

Immediate cause of death	DURATION
Bronchogenic Carcinoma Right Lung	5 mos
Due to	
Due to	
Other conditions Hypertensive Cardio-vascular Disease	2 years

(Include pregnancy within 3 months of death)

Major findings of operations Bronchogenic Carcinoma Date of op. Apr 2, 1947
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel J N Sugar MD M. D. or other
Address Mt. Rainier Md Date signed 4 July 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

06243

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 5 mos., 26 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 5 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 3014 13th Street, N. W. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GEORGE P. JONES

3.(b) Social Security Number: 577-18-3087

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virginia Pearl Jones

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): April 18, 1885

8. AGE: Years	Months	Days	If less than one day
62	2	15	hrs. min.

9. Birthplace: Esmont, Virginia (Town, County, and state)

10. Usual occupation: Engineer

11. Industry or business: - - -

FATHER — 12. Name: George M. Jones

FATHER — 13. Birthplace: Esmont, Virginia

MOTHER — 14. Maiden name: Annie Crobague

MOTHER — 15. Birthplace: Afton, Virginia

16. Informant: Decreased

Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof July 2, 1947 (month) (day) (year)

Cemetery or crematory:

Location: Danville, Va.

18. Funeral director: W. W. Chambers

Address: 1400 Clapin St., N.W., Wash. D.C.

19. July 2 1947 Rowland S. Phillips (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1947, at 6 50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8 1946, to July 2 1947

and that I last saw h.i.m. alive on July 2 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yr. 4 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D., M. D. or other

Address: Glenn Dale, Md. Date signed: 7-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13E

06244

CERTIFICATE OF DEATH

CP Reg. Diat. No. 243.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos., 28 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2231 Ontario Road, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: KATHRYN JONES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 2, 1916

8. AGE: Years	Months	Days	If less than one day
30	8	7	..... hrs. ..... min.

9. Birthplace: Prince Georges Co., Maryland
(Town, county, and state)

10. Usual occupation: Cleaner, - Day work

11. Industry or business: -

FATHER
12. Name: Eugene Jones
13. Birthplace: ? Maryland

MOTHER
14. Maiden name: Agnes Fletcher
15. Birthplace: Washington, D. C.

16. Informant: Deceased

Address

17. Burial - Date thereof 7/10/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt Comel

Location: Upper Marlboro Md

18. Funeral director: Fletcher Bros

Address: Upper Marlboro, Md

19. July 9, 1947 Rowland & Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9, 1947 at 4.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10, 1947, to July 9, 1947, and that I last saw her alive on July 9, 1947.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md Date signed 7/9/47

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06245

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 18 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 D. Street, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLES M. JUSTICE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna Justice

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): June 1, 1884

8. AGE: Years	Months	Days	If less than one day
63	1	13	hrs. min.

8. Birthplace: Jefferson City, Tennessee
(Town, county, and state)

10. Usual occupation: Watchman and General night mgr.

11. Industry or business: Atwood, Patuxent River Naval Base Lines

FATHER
12. Name: William Justice
13. Birthplace: Tidewater, Virginia

MOTHER
14. Maiden name: Sarah Aldrich
15. Birthplace: ? South Carolina

16. Informant: Deceased
Address:

17. Remove (Burial, cremation, or removal. Which?) Date thereof: July 14/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D. C.

18. Funeral director: Howe Chamber. C.

Address: 5th & E Sts

19. July 14, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1947 at 3.55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 25, 1946, to July 14, 1947 and that I last saw h. alive on July 13, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mo.
Due to	
Complications: Diabetes Mellitus	7½ mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: July 14, 1947

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

06246

Reg. Dist. No. 142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Pr. Geo. Suitland Md
City or town 4673 Homer ave
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Suitland Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 4673 Homer ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME LILLIAN KAY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Harry Ray
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1897

8. AGE:

Years	Months	Days	If less than one day
49	9	24	hrs. min.

9. Birthplace New York City
(Town, county, and state)
10. Usual occupation House duties
11. Industry or business

FATHER 12. Name	Czar
13. Birthplace	Russia
MOTHER 14. Maiden name	Kersie
15. Birthplace	Russia

16. Informant Harry Ray
Address 4673 Homer ave
17. Removal Date thereof July 9-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Washington DC
18. Funeral director Goldberg Funeral Home
Address 4417 - 9th St. N W
19. July 9 1947 Edna F. Coelin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1947, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1945 to 8 July 1947, and that I last saw h alive on 8 July 1947.

	OURATION
Immediate cause of death Metastatic Carcinoma of Liver	6 wks
Due to Adenocarcinoma Breast	2 yrs
Due to	
Other conditions Metastatic Carcinoma Pleura, Mediastinum and Breast (Include pregnancy within 3 months of death)	6 wks

Major findings:
Operations May 1945 Left Radical Mastectomy - Adenocarcinoma
Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice Mensh M.D.
M. D. or other
Address 1730 Eye St. NW Wash. 6 D.C. Date signed 7/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

06247

CERTIFICATE OF DEATH

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 26 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4223 24th Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William B. Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Lewis

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 27, 1899

8. AGE: Years	Months	Days	If less than one day
47			hrs. min.

9. Birthplace: Hillsboro, Texas (Town, county, and state)

10. Usual occupation: Navy Dept., Gage Division

11. Industry or business: Ordnance engineer

FATHER
12. Name: John W. Lewis
13. Birthplace: Kentuckey

MOTHER
14. Maiden name: Edmonia Truman
15. Birthplace: Texas

16. Informant: Elizabeth Lewis
Address: 4223 24th Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/15/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem.

Location: Maryland

18. Funeral director: The S. H. Kines Co.

Address: 2901 14th St. N.W.

19. 7/12 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 19 47 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral compression	
Due to: Intra cranial hemorrhage	
Due to: Fracture of the skull	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Acc. Date of: July '47

Where did injury occur? Mt. Rainier, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fell down stairs Injured at work? (9/3/47)

Deputy Medical Examiner

23. SIGNATURE: James S. Bond M.D. or Other

Address: Forestville, Md. Date signed: 7/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940a CB

06273

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince George

City or town Riverdale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, Institution, or street address where death occurred:
Eugene Leland Memorial Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 61 Virginia Ave., S.W.
(If rural, give LOCATION)

2.(a) If veleran, name war ✓

3.(a) FULL NAME Mason, Edwin Walter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife Mason, Mrs. Minnie

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1873

8. AGE: Years	Months	Days	If less than one day
74	5	13	...hrs. ...min.

9. Birthplace Warren, Michigan
(Town, county, and state)

10. Usual occupation Dealer in Surplus Govt. property

11. Industry or business

MOTHER FATHER

12. Name Mason, Judson Clement

13. Birthplace Massachusetts

14. Maiden name Davey, Elizabeth

15. Birthplace England

16. Informant Copied from Pt's chart

Address

17. Removal Date thereof 7-29-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

~~Cemetery or crematory~~ George Washington Univ. Hospital

Location Washington, D. C.

18. Funeral director J. J. Gaschis Sons

Address Ft. Meade, Md.

19. July 29 '47 Mrs. Jas. Severe
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947 at 4:10 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-7- 1947 to 7-27 1947 and that I last saw h.. alive on 7-27- 1947

Immediate cause of death	DURATION
Coronary Occlusion	6 hrs
Due to	
Due to	
Other conditions Urinary Retention, Urethral Stricture	

(Include pregnancy within 3 months of death)

Major findings of operation Urethral Stricture at Exam & cystoscopy Date of op. 7-22-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ferdinand Kelebir, M.D.

Address 1835 Eye St. NW D.C. Date signed 5-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108 C13 06248

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Chapel Oaks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Four Days
Hospital, institution, or street address where death occurred:
5710 Name St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County:
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 901 DeKalb Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lawernce Theodore Mobley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Katie Isabelle Mobley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May, 1886

8. AGE: Years: 61 Months: 2 Days: — If less than one day: hrs. min.

9. Birthplace: Saluda, S. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace:

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Mrs. Violetta Lorraine Waites
Address: 5710 Name St.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/23/47 (month) (day) (year)
Cemetery or crematory:
Location: Removed to Wash D. C.

18. Funeral director: Robert E. McGuire
Address: 1820-9th St NW.

19. July 23 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1947, at 1 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1947, to July 23 1947, and that I last saw h[illegible] alive on July 22 1947.

	DURATION
Immediate cause of death: Congestive Heart Failure	2 hrs.
Due to: Cardio-Vascular Disease	unknown
Due to: Pneumonia Bilateral	4 wks.
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John L. Robinson, M.D.
M. D. or other
Address: 160[illegible] Eastern Ave, N.E. Date signed: 7/23/47

VS A15 9-45.15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06249

Reg. Dist. No. 745

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hyattsville, Md.
(If outside city or town limits, write RURAL und give nearest towo)
How long in above place of death?
Hospital, Institution, or street eddress where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville,
(If outside city or towo limits, write RURAL and give nearest towo)
Street No.: 5023--38th Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MOORE, GEORGE W.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha I. Moore
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 8th, 1857

8. AGE: Years	Months	Days	If less than one day
90			..... hrs. ..... min.

9. Birthplace: Maryland (Towo, county, and state)
10. Usuat occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Mordecai Moore
13. Birthptace: Maryland

MOTHER
14. Maiden name: Eliza Loveless
15. Birthptace: Maryland

16. Informant: Owen F. Moore
Address: 3981-Alabama Ave., S.E. Washington DC

17. Burial (Burial, eremation, or removal. Which?) Date thereof: July 29, 1947 (month) (day) (year)
Cemelery or crematory: Epiphany Episcopal Cemetery
Location: Forestville, Maryland

18. Funeral director: Arthur E. Simmons Jr.
Address: 2007-Nichols Ave., S.E., Wash. DC

19. July 28 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 47 at ..... M

21. I CERTIFY that death occurred on the dale above stated; that I attended deceased from June 1 19 47 to July 27 19 47 and that I last saw h-im alive on July 27 19 47

Immediate cause of death	DURATION
Chr. myocarditis	
Due to	
Due to	
Other conditions: none	

(Include pregnaoey within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Dale of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Reece Bonnie M. D. or other
Address: 301-B H E Date signed: 7/27/47


RECEIVED
JUL 30 1947
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13C

06250

CERTIFICATE OF DEATH

CP Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 618 N. St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: Army following 1st World War

3.(a) FULL NAME: L. AVON NELSON

3.(b) Social Security Number: 577-36-0481

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 23, 1902

8. AGE: Years	Months	Days	If less than one day
44 44	7	12	hrs. min.

9. Birthplace: Greensboro, North Carolina
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business: —

FATHER
12. Name: Gray Nelson
13. Birthplace: Greensboro, North Carolina

MOTHER
14. Maiden name: Mary Sloan
15. Birthplace: Greensboro, North Carolina

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof 7-5-47 (month) (day) (year)
Cemetery or crematory: To Wash D.C.
Location:

18. Funeral director: Wm T Tolbert
Address: 1308 6th St N. W. Wash. D.C.

19. (Date rec'd by registrar) July 5, 1947 Rowland S Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 5, 19 47, at 1:10p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-4-47, 19, to 7-5, 19 47
and that I last saw h. I.M. alive on 7-5, 19 47

Immediate cause of death: PULMONARY TUBERCULOSIS — DURATION: 10 mos
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md Date signed: 7-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06251

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157e

CERTIFICATE OF DEATH

Reg. Diat. No. 232

M

1. PLACE OF DEATH:

County Prince Georges

City or town Bright Seat

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month

Hospital, Institution, or street address where death occurred:

Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Bright Seat

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bright Seat Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Harold Newman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 28, 1947

8. AGE: Years | Months 2 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Joseph George Harley

13. Birthplace Maryland

MOTHER 14. Maiden name Alberta Lucalia Newman

15. Birthplace Maryland

16. Informant Alberta L Newman

Address Landover, Md

17. buried (Burial, cremation, or removal. Which?) Date thereof July 3 1947 (month) (day) (year)

Cemetery or crematory Mt Carmel

Location Upper Marlboro Md

18. Funeral director Clarence Forcare

Address Mitchellville Md

19. July 2 1947 (Date rec'd by registrar) R Emmett Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1947 at 6 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Congenital heart disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy medical Examiner

23. SIGNATURE James D. Bond M. D. or other

Address Forestville Md Date signed 7-1-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170C

06252

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Summers O'Neill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1918

8. AGE: Years 29 | Months | Days | If less than one day hrs. min.

9. Birthplace Marlowe W. Va. (Town, county, and state)

10. Usual occupation Bartender

11. Industry or business Hunter Tavern, Edgewood, Md

FATHER 12. Name William O'Neill
13. Birthplace Virginia

MOTHER 14. Maiden name Flora Reynolds
15. Birthplace Virginia

16. Informant Hospital Records
Address Prince Georges General Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 47 (month) (day) (year)

Cemetery or crematory Mt. Harmony Cem.
Location Mr. Airings

18. Funeral director W. H. Hutchins
Address Airings Md

19. July 27 1947 (Date rec'd by registrar) Grace L. Hutchins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Depressed fracture of skull	
Due to Traumatic amputation of left arm	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7-24-47
Where did injury occur? Upper Marlboro Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Hills Landing Rd
Manner of injury Auto accident Injured at work?

Report to Medical Examiner

23. SIGNATURE James D. Ford M. D. or Other
Address Forestville Md Date signed 7-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

06253

Evidence for corrections is shown on Film No. G-312 - 8/26/47.

2411 N. Charles St., Baltimore 13/a

CERTIFICATE OF DEATH

Reg. Dist. No. 745

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:

County: Prince George

City or town: Riverdale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 min.

Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital

How long in hospital or institution? 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Riverdale Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6205 60th Pl.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Oehmler, Mrs. Maude Deliah

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife: Oehmler, Louis Alexander

7. Birth date of deceased (mo., day, yr.): June 4 1885. 6.(c) If alive, give age: years

8. AGE: Years 62 | Months 1 | Days 24 | If less than one day: hrs. min.

9. Birthplace: Georgetown, Washington D.C.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER 12. Name: Kidwell, Levi

13. Birthplace:

MOTHER 14. Maiden name: Biggs, Margaret

15. Birthplace:

16. Informant: Mr. Robert Oehmler

Address: 6205 60th Pl. Riverdale Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-31-47 (month) (day) (year)

Cemetery or crematory: F. Lucas Cemetery

Location: Washington D.C.

18. Funeral director: H. W. Chambers Co.

Address: Riverdale, Md.

19. July 29 1947 (Date received by registrar) James Seney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28th 1947, at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra cranial hemorrhage	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other

Address: Residence Date signed: 7-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

06254

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 4 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1410 First St., S. W
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Raymond A. Onley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Alice C. Onley

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): October 10, 1903

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
43	8	23		

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Dental Technician Apprentice

11. Industry or business: -

FATHER
12. Name: John R. Onley
13. Birthplace: Montgomery Co., Maryland

MOTHER
14. Maiden name: Agnes Henson
15. Birthplace: Prince Georges Co., Maryland

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 4 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: Eugene Ford

Address: 1313-4th St. S.W. Wash. D.C.

19. July 3, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1947, at 10 75- M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/28 1947, to 7/3 1947 and that I last saw h[illegible] alive on 7/3/47 - 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis -	6 mo's 1 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 7/3/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13 1a

06255

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince George
City or town Silver Hill Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town Silver Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1-901 Silver Hill Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles B. Pettit

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 28th 1866

8. AGE: Years	Months	Days	If less than one day
81	2	9	____ hrs. ____ min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation Storekeeper
11. Industry or business
FATHER 12. Name Hudson Pettit
13. Birthplace Camden N. J.
MOTHER 14. Maiden name Mary Clawson
15. Birthplace Washington D.C.
16. Informant Mrs Edwin Oliver
Address 830 N Ll N.E.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-47 (month) (day) (year)
Cemetery or crematory Congressional
Location Washington, DC
18. Funeral director W. W. Chambers Co
Address 517 11th St S.E.
19. July 7 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947 at 2:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to July 7 1947 and that I last saw him alive on July 5 1947

	DURATION
Immediate cause of death Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James F. Boyd M.D. or other
Address Anacostia Md. Date signed 7-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

06256

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Gro. Geo. County.
City or town wilderoft Md. P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Gro Geo Co.
City or town R.F.D. Wilderoft Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Nevett Pfeiffer

3. (b) Social Security Number 579-07-6457A.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rosetta Pfeiffer
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 29, 1875.

8. AGE: Years	Months	Days	If less than one day
72	2		hrs. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual occupation Stone Mason
11. Industry or business Construction
FATHER 12. Name James L. Pfeiffer
13. Birthplace Md.
MOTHER 14. Maiden name Hanna E. Clifford
15. Birthplace Baltimore Md
16. Informant Mrs Rosetta Pfeiffer
Address wilderoft Md.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof July 11, 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland Md
18. Funeral director E. Gasche sons
Address Hyattsville Md.
19. 7/10 (Date rec'd by registrar) 1947 Amanda Doong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1947 at 5:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1945 to 7/9/47
and that I last saw h.i.m. alive on 7/9/47

Immediate cause of death	DURATION
Angina Pectoris	One year
Due to Coronary arteriosclerosis	8-10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J Sweeney M.D.
M. D. or other
Address 1233 Monroe St NE Date signed 7/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

06257 D 245

Reg. Dist. No. 146

1. PLACE OF DEATH:

County Prince Georges

City or town Mt Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Treatment

Hospital, Institution, or street address where death occurred:

35th and Allison sts

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1828 Newton st NE

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Powell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1936

8. AGE: Years 11 Months Days If less than one day hrs. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation student

11. Industry or business school

FATHER 12. Name Richard Powell Jr

13. Birthplace Virginia

MOTHER 14. Maiden name Helen Tracey

15. Birthplace Baltimore, Md

16. Informant Mrs Helen Powell

Address 1828 Newton st. N.E. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/4/47 (month) (day) (year)

Cemetery or crematory Louden Pk Cem.

Location Balt. Md

18. Funeral director D. H. Hines Co.

Address 2901 - 14th St N.W.

19. 7/21 (Date rec'd by registrar) 1947 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia	
Due to drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-1-47

Where did injury occur? Mt Rainier (City or town) P.G. (County) Md (State)

Injured at home, farm, industry, public place (where)? Storm Sewer

Means of injury drowned Injured at work? no

Deputy medical Examiner

23. SIGNATURE M. D. or other

Address Forestville Md Date signed 7-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

06258

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Pr.Geo.
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Pr.Geo.Gen'l
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr.Geo.
City or town Croome
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rawlings, Mrs. Lillie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife Mr. Arthur Rawlings
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 12, 1900

8. AGE: Years 47 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Albert Curtin
13. Birthplace Md.

MOTHER 14. Maiden name Suzanne Taylor
15. Birthplace

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14, 1947 (month) (day) (year)
Cemetery or crematory St Thomas Cemetery
Location Croom, Maryland

18. Funeral director Arthur E. Simmons Sr
Address 2007 Nicholson Ave S.E.

19. 7/12 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-11 1947, at 3:25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1947, to July 12 1947 and that I last saw h.. alive on July 12, 1947

Immediate cause of death Ruptured ovarian cyst & hemorrhage — DURATION 7 hrs.

Due to

Due to

Other conditions Chronic appendicitis intestinal obstruction
(Include pregnancy within 3 months of death)

Major findings of operation Ovarian cyst, ruptured. Date of op.

Autopsy results Intestinal obstruction (PO)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Donald W. Mitchell M.D. M. D. or other
Address 1746 K St NW Wash DC Date signed 7/12/47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06259

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 231

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15 9-45-15M

1. PLACE OF DEATH:
County Pr.Geo.
City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8days
Hospital, institution, or street address where death occurred: Pr.Geo.Gen'l
How long in hospital or institution? 8days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Pr.Geo.
City or town Berwyn (If outside city or town limits, write RURAL and give nearest town)
Street No. 6805 48th Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rook,Mr.William B.

3.(b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced M
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept.28th ,1869
8. AGE: Years 78 Months Days If less than one day hrs. min.
9. Birthplace Franklin,Ohio (Town, county, and state)
10. Usual occupation Carpenter(Retired)
11. Industry or business
FATHER 12. Name Thomas E.Rook
13. Birthplace Pa.
MOTHER 14. Maiden name Mary Allison
15. Birthplace Pa.
16. Informant Mr.Thomas E.Rook (son)
Address 411 2nd St.S.E. Wash.D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22, 1947 (month) (day) (year)
Cemetery or crematory Ft Lincoln Cemetery Md
Location near Washington D. C.
18. Funeral director F. Gasch's Sons
F. Gasch's Sons
Address Bladensburg Maryland.
19. 7/20 19 47 Amanda Dorsey Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-19 19 47 at 3:25a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 19 47 to July 18 19 47
and that I last saw him alive on July 18, 1947 19

Immediate cause of death	DURATION
Chr. Congestive Heart Failure; myocarditis - auricular fibrillation	15 yrs +
Due to Arterio-sclerotic Cardio-vascular disease	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W.L. Etienne M.D. M. D. or other
Address Berwyn, Md Date signed 7-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06260

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Beltsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred? Edmonston Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Beltsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edmonston Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Arabelle Fields Ross

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Lee N. Ross

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): Aug 1 1913

8. AGE:	Years	Months	Days	If less than one day
	33	11	3	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: Samuel Fields

13. Birthplace: Maryland

MOTHER

14. Maiden name: Henrietta Hebron

15. Birthplace: Maryland

16. Informant: Lee N. Ross

Address: Beltsville Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 3. 1947 (month) (day) (year)

Cemetery or crematory: Washington Funeral Co

Location: 467 N st N.W. Washington D.C.

18. Funeral director: F Gaschi sons Inc

Address: Hyattsville Md.

19. July 3 1947 (Date rec'd by registrar) James Sever Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 19 47, at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
(a) Coronary Thrombosis	
Due to (b) Coronary Occlusion	
Due to (c)	
Due to (d)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other

Address: Hyattsville Md Date signed 7-3-47


RECEIVED
JUL 9 1947
BUREAU F.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

06261

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Pr. Geo Co
City or town Columbia Park, Lanover, md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Pr. Geo. Co
City or town Columbia Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. Lanover, md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James O. Sands

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	N	Married

6.(b) Name of husband or wife Jessie Sands
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec-17-1897

8. AGE: Years	Months	Days	If less than one day
49			..... hrs. ..... min.

9. Birthplace Wash. DC (Town, county, and state)
10. Usual occupation Auto Mechanic
11. Industry or business

FATHER
12. Name Harvey Sands
13. Birthplace Washington - DC.

MOTHER
14. Maiden name Emma Waters
15. Birthplace Washington DC.

16. Informant Jessie Sands
Address Columbia Park, Lanover, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18 1947 (month) (day) (year)
Cemetery or crematory Washington Natl. Cem.
Location Suitland Rd. Maryland

18. Funeral director W.W. Chandler
Address 577-11 sts S.E.

19. 7/15 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1947, at 9:23 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-14 1947, to 7-14 1947
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 years or more
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Dayton A Watkins MD (M. D. or other)
Address 5306 Annapolis Rd, Hyattsville Md Date signed 7-15-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06262

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

Soldiers Home

How long in hospital or institution? June 4, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington D C

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3033 8th N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME Dora A Schmitt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 1850

8. AGE:

Years	Months	Days	If less than one day
97	6		..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: None

11. Industry or business: .....

FATHER

12. Name: John Schmitt

13. Birthplace: Germany

MOTHER

14. Maiden name: Magdaline Schmitt

15. Birthplace: Germany

16. Informant: John J. Schmitt

Address: 1430 D St S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16, 1947 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Washington D.C.

18. Funeral director: Robert A Mattingly

Address: 131-11th St S.E. Wash. D.C.

19. July 15 1947 (Data rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1947, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 13 1947 and that I last saw h.. alive on July 13 1947

Immediate cause of death	DURATION
Arteriosclerotic Heart disease	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thomas Hollins M.D. (M. D. or other)

Address: 322 - H St NE Date signed 7-14-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

06263

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days, 7½ hours

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? 14 days 7½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Almshouse
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

DAVID SHAFFER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 14, 1864

8. AGE: Years	Months	Days	If less than one day
83	0	2	..... hrs. ..... min.

9. Birthplace: Laurel, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Charles F. Shaffer
13. Birthplace: Md.

MOTHER
14. Maiden name: Jane F. Purcell
15. Birthplace: Va.

16. Informant: Self
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-18-47 (month) (day) (year)
Cemetery or crematory: P. G. Co. Memorial Park
Location: Forestville, Md.

18. Funeral director: T. Frank Pyle
Address: Upper Marlboro, Md.

19. 7/18 19 47 Amanda Dewrey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 19 47 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h. IM alive on 16 JULY 19 47

Immediate cause of death	DURATION
Cancer Cachexia	
Due to Primary Carcinoma Head Pancreas with Metastasis to Liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NO OPERATION Date of op.:

Autopsy results: SEE ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Leslie Finch MD
M. D. or other

Address: 6803 PINEWAY COLL. HTS. HYATTSVILLE MD. Date signed: 17 July 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

06264

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hrs. 40 minutes
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 5 hrs. 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Missouri County:
City or town: Kansas City (If outside city or town limits, write RURAL and give nearest town)
Street No. 125 South Ceder (If rural, give LOCATION)
2.(a) If veteran, name war: Navy

3.(a) FULL NAME: James Willard Sims

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

8.(b) Name of husband or wife:
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 26, 1927

8. AGE: Years: 19 Months: Days: If less than one day: hrs. min.

9. Birthplace: Missouri (Town, county, and state)

10. Usual occupation: Seaman

11. Industry or business: U. S. Navy

FATHER
12. Name: James Sims
13. Birthplace:

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: U. S. Navy records
Address: Naval Receiving Station

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 26 1947 (month) (day) (year)
Cemetery or crematory: Lincoln Cemetery
Location: Suitland
18. Funeral director: W. W. Chambers Co.
Address: 5801 Cleveland ave, Riverdale, Md

19. 7/26 (Date rec'd by registrar) 19 47 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1947 at 12:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Contusion and laceration of left frontal lobe	
Due to Laceration of the brain stem	
Other conditions Multiple petechial hemorrhages into the brain substance	
Multiple contusions and abraisions of the body and extremeties	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: Given above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 7/24/47
Where did injury occur? Central Avenue (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Road
Manner: Passenger in a car that ran off the Road.

Deputy Medical Examiner

23. SIGNATURE: James T. Boyd M. D.
Address: Forestville, Md. Date signed: 7/25/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

06265

CERTIFICATE OF DEATH

Reg. Diat. No. 242

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legally.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Prince George

City or town Brandywine Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Prince George

City or town Brandywine Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME IRA LEON SMITH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Cornelia J. Smith

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 1856

8. AGE: Years 91 | Months | Days | If less than one day ...hrs. ...min.

9. Birthplace Louisa County Virginia
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

FATHER 12. Name Pendleton Smith

13. Birthplace Charlottesville Va

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Frances L. McCarthy

Address 4607 Conn Ave NW DC.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1947 (month) (day) (year)

Cemetery or crematory Beaver Dam

Location Louisa

18. Funeral director W W Chambers & Son

Address 517-11 St SE

19. July 3 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/10 1947 to 7/3 1947 and that I last saw h...alive on 6/20 1947

Immediate cause of death	DURATION
Myocardial	
Decompensation	
Due to Cardiac Neurosis	4 yrs
Due to Dia.	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Dewson M.D.
M. D. or other

Address Waldorf Md. Date signed 7/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

06266

CERTIFICATE OF DEATH

Reg. Diat. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred: 6121 - Shady Side Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6121 - Shady Side Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Louis Sollers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie M. Sollers

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Dec 4, 1891

8. AGE:

Years	Months	Days	If less than one day
55			hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Helper

11. Industry or business: Dy truck

FATHER

12. Name: William Sollers

13. Birthplace: Washington D.C.

MOTHER

14. Maiden name: Cora Lee Tanner

15. Birthplace: Virginia

16. Informant: Mrs Elsie M Sollers

Address: 6121 Shady Side Ave Capitol Hts

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 11-47 (month) (day) (year)

Cemetery or crematory

Location: Washington D.C.

18. Funeral director: W.W. Chambers Co.

Address: 512 H St. S.E.

19. July 11 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1947, at 11:45A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James J. Lord M. D. or other

Address: Prestwould Hwy Date signed 7-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06267

13b CO

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 24 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1605 Graceland Court, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Jesse Starks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 3, 1907

8. AGE: Years	Months	Days	If less than one day
40	3	28	hrs. min.

9. Birthplace: Leverne, Georgia
(Town, county, and state)

10. Usual occupation: Plumbers Helper

11. Industry or business: -

FATHER
12. Name: Jesse Starks
13. Birthplace: ? Georgia

MOTHER
14. Maiden name: Elizabeth Doll
15. Birthplace: ? Georgia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 5/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D. C.

18. Funeral director: E. B. Clarke

Address: 1400 Fla. Ave. N.E.

19. July 31, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 47, at 4 48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/6- 19 47, to 7/31 19 47 and that I last saw h. alive on 7/31 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel L. D. Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 7/31/47

VS A15 6-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
AUG 9 1947
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06268

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92 P

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George County
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Prince George County Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4100 5th St N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie E. Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife: Morris E.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 21, 1887

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: ~~Maryland~~ D.C.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Travis Beach
13. Birthplace: Virginia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Maryland

16. Informant: P. R. England
Address: 4100 5th Street N. W.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/10/47 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Washington, D. C.

18. Funeral director: The S. H. Hines Company
Address: 2901 - 14th St. N. W. Wash. DC

19. 7/7/47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1947 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 7 1946, to July 7 1947
and that I last saw h... alive on July 7 1947

Immediate cause of death	DURATION
Cerebral accident	2 days
Due to: Arteriosclerosis	Years
Due to:	
Other conditions: Mitral stenosis; auricular fibrillation	Years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Lovi Mendel M.D.
M. D. or other
Address: College Park Md. Date signed: 7/7/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06269

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Prince George's
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Eight days and four hrs.
Hospital, Institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? Eight days and four hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County ~~Prince George~~ Howard
City or town Box 528, Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME
ELIZABETH THOMPSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Levi Thompson
6.(c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) October 13th, 1886

8. AGE:

Years	Months	Days	If less than one day
60	9	7	..... hrs. ..... min.

9. Birthplace Columbus, Ohio
(Town, county, and state)
10. Usual occupation Seamstress
11. Industry or business Raleigh Mfg. Co.
FATHER 12. Name Robert L. Masters
13. Birthplace Ohio
MOTHER 14. Maiden name Theresa ?
15. Birthplace Ohio
16. Informant Mr. Harry R. Huber (Son)
Address Box 528, Laurel, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill Cem.
Location B. & A. Co., Md.
18. Funeral director A. Howard Evans
Address 1405 S. Charles St. Balto 39 Md.
19. 7-22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947, at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6th 1947 to July 20 1947
and that I last saw h.. alive on July 20 1947

Immediate cause of death	DURATION
Coronary Thrombosis Spotted Fever	14 days
Due to	.....
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert S McKinney M.D.
M. D. or other
Address 402 Main St Laurel Md. Date signed 7/21/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

S 06270

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 910 Third St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: TRAVERS, SADIE L.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Preston Travers

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): January 23, 1917

8. AGE: Years	Months	Days	If less than one day
30	5	11	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - - -

FATHER
12. Name: Charles T. Wright
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Louise V. Mears
15. Birthplace: Windsor, Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 4, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: Alexander S. Pope

Address: 315-15th street S.E. Wash., D.C.

19. July 4, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1947 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/3 1947, to 7/4 1947

and that I last saw her alive on 7/4 1947

Immediate cause of death	DURATION
pulm. tuberculosis	2-1/2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

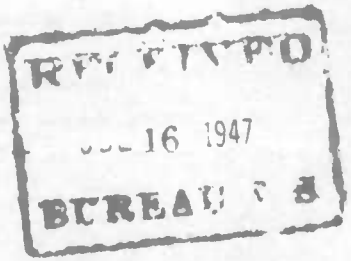
23. SIGNATURE: Daniel Leo Finucane MD
M. D. or other

Address: Glenn Dale, Md. Date signed: 7/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13a

06271

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County Prince George

City or town Westfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Still

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Westwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bald Eagle Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Alfred Wall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Widowed

6.(b) Name of husband or wife Jane Wall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4, 1861

8. AGE: Years 86 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Thomas Wall

13. Birthplace Unknown

MOTHER 14. Maiden name Emma Wood

15. Birthplace Maryland

16. Informant Mrs. Johnson Address West Wood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory Brooks Cemetery Nottingham

Location Nottingham, Md.

18. Funeral director Eugene Ford

Address 1213 - 4th St. S.W. Wash. D.C.

19. July 2-5 1947 F. H. Billingsley (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiosclerosis and low renal decom	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Forestville Md. Date signed 7-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06272

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Pr. Geo.

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Pr. Geo. Gen'l Hosp.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Landover Hills

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4802 72nd Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Wallace, Mr. James

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mrs. Theresa Wallace

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4-23-1909

8. AGE: Years	Months	Days	If less than one day
38	2	18	hrs. ..... min.

9. Birthplace: WASHINGTON - D.C.

(Town, county, and state)

10. Usual occupation: ACCOUNTANT -

11. Industry or business

FATHER 12. Name: HENRY - WALLACE

13. Birthplace: NEW YORK

MOTHER 14. Maiden name: ISABELLA FUNSTOWN

15. Birthplace

16. Informant: MRS. THERESA WALLACE - (WIFE)

Address: 4802 - 72ND AVE. - LANDOVER HILLS - MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Md.

18. Funeral director: E. W. Chambers Co.

Address: 317 - 11 ST NW.

19. 7/11 1947 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-11- 1947, at 4:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-9 1947, to 7-11 1947

and that I last saw h[illegible] alive on 7-10 1947

Immediate cause of death	DURATION
Coronary Occlusion & Hypostatic Pneumonia	4 mo. 5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M.D.

M. D. or other

Address: Mt. Rainier Md. Date signed 7.11.47

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06274

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 minutes

Hospital, institution, or street address where death occurred: Prince George's General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Cottage City (If outside city or town limits, write RURAL and give nearest town)

Street No. 3802 37th Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Martin Weaver

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Catherine Virginia Weaver

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.): December 21, 1904

8. AGE: Years: 42 Months: Days: If less than one day ... hrs. ... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Gasoline

FATHER 12. Name: Henry Bushrod Weaver

13. Birthplace: unknown

MOTHER 14. Maiden name: Hannah Freeman

15. Birthplace: unknown

16. Informant: Catherine V. Weaver

Address: 3802 37th Ave. Cottage City, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: July 5 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Colma ~~Manor~~ Md

18. Funeral director: F. Gasch's Sons

Address: Hyattsville Md

19. 7/4 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1947, at 10:07 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Hemorrhage and shock | DURATION

Due to: gun shot wounds of head, chest and abdomen

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: homicide Date of: 7/2/47

Where did injury occur? Cottage City (City or town) Pr. Geo. (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury: shot during altercation Injured at work? no

Deputy Medical Examiner

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Date signed 7-3-47

(I) (M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06275

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1220 Messer Place, S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Lilly Williams

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 24, 1903

8. AGE Years	Months	Days	If less than one day
44 44	0	27	hrs. min.

9. Birthplace: Lawrence, South Carolina (Town, county, and state)

10. Usual occupation: None

11. Industry or business: -

FATHER — 12. Name: Tom Williams

13. Birthplace: ?

MOTHER — 14. Maiden name: Rose E, (?)

15. Birthplace: ?

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 21/47 (month) (day) (year)

Cemetery or crematory

Location: Washington, D C

18. Funeral director: Walter E. Hunter

Address: 2512 Sheridan Rd. S.E.

19. July 21, 1947 (Date rec'd by registrar) Rowland & Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1947, at 8 9 AM PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/27 1947, to 7/21 1947

and that I last saw him alive on 7/21/ 1947

Immediate cause of death: Pulmonary Tuberculosis - DURATION: 3 mos 24 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: July 21, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

06276

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County PRINCE GEORGE'S
City or town LAUREL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 YEARS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGE'S
City or town LAUREL
(If outside city or town limits, write RURAL and give nearest town)
Street No. 409 GOREMAN AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM LAFAYETTE WILLIAMS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife CATHERINE WILLIAMS
6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) AUG 13 1892

8. AGE: Years	Months	Days	If less than one day
54			hrs. min.

9. Birthplace ST. MARY'S CO. MD.
(Town, county, and state)
10. Usual occupation STATE RD. DEPT.
11. Industry or business
FATHER 12. Name WILLIAM H WILLIAMS
13. Birthplace MARYLAND
MOTHER 14. Maiden name NOT KNOWN
15. Birthplace MARYLAND
16. Informant MRS. CATHERINE WILLIAMS
Address 409, GORMAN, AVE. LAUREL
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JULY 9 1941 (month) (day) (year)
Cemetery or crematory ST. MARYS
Location LAUREL
18. Funeral director W W Chambers Co.
Address Riverdale, Md
19. July 6, 1947 (Date rec'd by registrar) M. Bruchsrans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 6 1947, at 5:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 6 1947, to JULY 6 1947
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Myocardial Insufficiency	10 min
Due to Myocardial Infarction	8 mo
Due to Coronary Thrombosis	8 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A Stephens M.D. M. D. or other
Address Laurel, Maryland Date signed 7/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Certificate signed in absence of
Dr. N. B. Eberwein by authorization
of Dr. Boyd.
J. Albertson, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06277

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges Co

City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Pro Georges Co

City or town: Brentwood Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3504 Webster street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Henry Ulysses Wilson Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Wilson

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Sept 7, 1887.

8. AGE: Years	Months	Days	If less than one day
59	9	7	hrs. min.

9. Birthplace: Richmond Virginia
(Town, county, and state)

10. Usual occupation: Hotel and Restaurant

11. Industry or business: supply salesman

FATHER
12. Name: George Wilson
13. Birthplace: Va

MOTHER
14. Maiden name: Rosa Lynch
15. Birthplace: Va

16. Informant: Mary Wilson
Address: Brentwood Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 17, 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery
Washington D. C.

Location:

18. Funeral director: F Gasch's Sons
F. Gasch's sons

Address: Hyattsville Md.

19. July 17 1947 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 19 47, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 19 47, to July 14 19 47 and that I last saw him alive on July 14 19 47

Immediate cause of death	DURATION
generalized Toxaemia	6 month
Due to: Miliary Tuberculosis of both lungs	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Miliary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm H Norton M.D.
M. D. or other

Address: 3827 34th-Mt. Rainier, Md. Date signed: 7/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

06278

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Ardwick Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years

Hospital, Institution, or street address where death occurred:
Monro Street and Ardwick Road

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Ardwick
(If outside city or town limits, write RURAL and give nearest town)

Street No. Monro Street and Ardwick Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur Dewey Worley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Myrtle Worley

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) August 11, 1899

8. AGE: Years 47 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Building

FATHER
12. Name Herbert Worley
13. Birthplace Virginia

MOTHER
14. Maiden name Rebecca Merchant
15. Birthplace Maryland

16. Informant Mrs. Myrtle Worley
Address Ardwick, Maryland

17. Burial Date thereof July 26 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft Lincoln
Location near Washington DC

18. Funeral director E Gobeche Sons
Address Hyattsville Md.

19. 7/24 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947, at 9:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Deputy medical Examiner
M. D. or other

Address Forestville Md Date signed 7-23-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 120a

06279

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Brandywine Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr. Geo.
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Herbert Albert Young

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widow

6.(b) Name of husband or wife Sadie Young
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12th - 1882

8. AGE:

Years	Months	Days	If less than one day
65	11	15	hrs. min.

9. Birthplace Brandywine Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business State Roads
FATHER 12. Name Dennis Young
13. Birthplace Brandywine, Md
MOTHER 14. Maiden name Elizabeth
15. Birthplace Md
16. Informant Elsie Ford
Address Brandywine Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-29-47 (month) (day) (year)
Cemetery or crematory P. E. Maryland
Location
18. Funeral director John S. Rhines & Co
Address 901-3 St. S.W.
19. July 26 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~July 26~~ 7/22 1947, to July 26 1947
and that I last saw him alive on July 26 1947
Immediate cause of death Gastro Enteritis — DURATION 5 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John E. Powers M D
M. D. or other
Address Brandywine, Md Date signed 7/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING